REQUEST FOR INFORMATION 6-25
Localization of Selected State Hospitals

This is a Request for Information (RFI) issued by the Indiana Department of Administration (IDOA) in conjunction with the Indiana Family and Social Services Administration (FSSA). This RFI requests responses for the operation and management of Evansville State Hospital, Richmond State Hospital, and Southeast Regional Treatment Center (on the grounds of Madison State Hospital). There will not be a contract resulting directly from this RFI; however, respondents to this RFI will be placed on the list of potential respondents and will receive an announcement of any Request for Proposal (RFP) that may arise from this RFI.

SITUATION

FSSA currently owns and operates several state mental health hospitals across Indiana, which means they are overseen in Indianapolis while the actual care is often delivered far away. State hospitals should be free from the shackles of a bureaucracy which is cumbersome and benignly neglectful at best, and at worst meddling and contradictory.

When state government decides that a hospital's care model has clearly stagnated, someone in Indianapolis becomes responsible for downsizing or closing the institution. This is typically done with little regard for the effect such action has upon the local community, not to mention the trauma to the families, and most importantly, to the patients.

This RFI represents an effort to allow the communities which house these facilities, along with the employees who operate them, to have a role in developing a governance model that keeps pace with clinical and operating changes. Hospitals that stay current stay in operation, and therefore, remain a vital part of the local economy.

This effort is being called "localization," meaning that not-for-profit providers are awarded the contracts to run/operate the facilities. Current employees will be offered jobs at or even above their current wages and with retirement and healthcare benefits equal to state government.

Cost savings is not the ultimate goal for this effort. This initiative may or may not enable hospitals to realize cost savings, but localization will enable communities to exercise control over their own economic destinies.

BACKGROUND

Richmond State Hospital, Madison State Hospital, and Evansville State Hospital are state operated psychiatric hospitals. Indiana's state hospitals serve many roles in their respective communities. They are inpatient treatment units for those in need of an intensive level of treatment, research facilities for students

and professionals in the fields of mental health and addiction, and good neighbors to the surrounding community, adding to the local economy and culture.

Richmond State Hospital has served persons with mental illness since 1911. The Residential Treatment Center opened in 1992 and in August of 2002 the Clinical Treatment Center, emphasizing active treatment using the treatment mall approach, was opened.

The hospital is composed of five service lines that provide care to adults with mental illness and/or adults who are developmentally disabled, adults with substance abuse needs, and adolescents who are seriously emotionally disturbed. Richmond State Hospital currently has 312 beds. Service lines include: Substance Abuse (101 beds-includes dually diagnosed), Adult Services (65 beds), Life Skills (60 beds), Transition (36 beds), Youth Services (20 beds) and Adult Mentally Ill and Developmentally Disabled (30 beds).

Madison State Hospital has served persons with mental illness since August 1910. In September of 1910, 476 patients were transferred by rail from Central State Hospital in Indianapolis. Madison State Hospital's current capacity is 150 beds.

The hospital is composed of two service lines that provide care to adults with mental illness and/or adults who are developmentally disabled. Service Lines include: Adult Psychiatric Services (90 beds) and Adult Mentally Retarded/Developmentally Disabled (60 beds, 45 of which are certified as Intermediate Care Facility for the Mentally Retarded (ICF/MR)).

Evansville State Hospital has served persons with mental illness since 1890. A replacement hospital, which has a capacity of 168, was opened in September 2003.

The hospital is composed of three service lines that provide care to adults with mental illness and/or persons who are developmentally disabled. Service lines are: Development Training Services (32) (ICF/MR certified), Geriatric Services (34 beds), Adult Continuing Treatment (102 beds).

Treatment at all hospitals is individualized through interdisciplinary assessments and may include stabilization of symptoms through psychopharmacology, management of medical problems, individual and group therapy, patient and family education, rehabilitation and recreation therapy, academic and skills training, vocational training, developmental skills training and supported employment.

All hospitals continue to maintain Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation for hospitals. Certain units at

these hospitals also meet JCAHO standards related specifically to behavioral health. The units primarily meeting the behavioral health care standards are the units that serve the developmentally disabled population. Madison State Hospital and Evansville State Hospital have maintained certification as an Intermediate Care Facility for the Mentally Retarded (ICF/MR). Richmond also has maintained JCAHO accreditation for laboratory services. All the facilities maintain Centers for Medicaid/Medicare Services (CMS) through Federal Regulations Title 12, 482 conditions of participation for hospitals. This certification is for the individuals at Madison and Evansville who are 65 and over, and for individuals 22 and under in Richmond's adolescent group. Maintaining these accreditations and certifications improves quality of care and maintains reimbursement status.

Please refer to http://www.in.gov/fssa/sof/hospitals.html for detailed financial and clinical information on each facility.

FSSA is especially interested in entering into operation and management agreements with locally-based not- for-profit organizations that will direct these facilities so they continue providing value to patients, the State, and the local communities. The State, through FSSA, intends to continue funding the operation of these hospitals according to the current form and function for the next three years. Beyond this time, FSSA desires to move to a contractual arrangement where State funding continues based on a per-patient rate.

This RFI, a step in the procurement process, has two key objectives: 1) Inform prospective respondents of the functions and processes that FSSA expects will become the responsibility of the operator and 2) Solicit respondent information that will help FSSA develop the resulting RFP.

OPERATOR RESPONSIBILITIES

FSSA anticipates that the successful respondent will enter into a contract assuming responsibility for continuing operation and management of the hospital. Such a contract may include the following expectations:

- Current state hospital employees who pass a drug screen and criminal background check will be offered employment with the operator at their current salary and with a comparable benefits package.
- The operator will manage the hospital's budget and regularly report to FSSA on budget performance.
- The operator will accept on a timely basis patients as required by FSSA or the courts, including developmentally disabled and forensic patients as needed.
- The operator will maintain JCAHO accreditation and CMS certification.

- The operator will comply with all requirements of the Health Insurance Portability and Accountability Act (HIPAA).
- The operator will provide for off-grounds medical care of patients.
- The operator will provide for legal representation in all areas of litigation involving facility operation and patient care.
- The operator will provide staff training in therapeutic interventions and patient rights.
- The operator will manage patient spending accounts and the patient recreation fund.
- The operator will track court orders and court reports on involuntarily committed patients.
- The operator will have a mechanism for reporting patient abuse and neglect.
- The operator will have a method of transporting patients to court hearings and off-grounds activities and appointments.
- The operator will create a continuous improvement process, performance management system, and an employee grievance procedure consistent with state and federal laws.
- The operator will produce such reports to the Social Security Administration and the U.S. Secret Service regarding forensic patients as are required by state and federal law.
- The operator will make a good faith effort to subcontract services to qualified minority or women-owned business, in accordance with the State's MBE/WBE goals as well as consider subcontracts with companies that provide employment and training opportunities for Indiana's citizens with disabilities.
- The operator will provide for the adequate physical security and routine maintenance of the facility.

REQUEST FOR INFORMATION

The RFP process will be open to all respondents regardless of their decision to participate in this RFI. FSSA seeks creative, high-level responses to the RFI components. FSSA is especially interested in receiving the following information from each respondent's RFI submission:

- The contemplated composition and organization of the responding entity, including leadership, board members, consultants and other advisors.
- The community the respondent represents and the hospital it would propose to operate and manage.
- Respondent's qualifications and related experience necessary to provide quality care for individuals with mental illness and/or developmental disability as well as addiction services including familiarity with current practice guidelines.
- Respondent's ideas on the future direction of mental health care and how the facility they manage will evolve and adapt to remain relevant and valuable.

- Qualifications and related experience necessary to provide excellent management of personnel and resources in a hospital setting.
- Respondent's qualifications and related experience with facility maintenance and capital improvements.
- Respondent's ideas on effective performance measures, quality indicators, and other accountability systems that will serve to demonstrate that the facility is being well managed.
- Proposed ideas to move funding from the current practice within the next three years to a contractual arrangement where State funding is based on a per-patient rate
- Proposed methods for directing any cost savings the respondent achieves back into the mental health system.
- Respondent's plan for patients in need of long-term care beds and how the respondent will work with the community providers to transfer the ready-to-be-discharged patients back into the community.
- Proposed methods of patient billing and collections, including first party liability**.**
- Programs or services that the respondent contemplates adding to the hospital.
- Any programs or services currently offered that the respondent feels could be eliminated and how the resources would be redirected.
- Respondent's ideas for providing some form of performance assurance to the State (e.g. performance bond or other mechanisms).
- Respondent's ideas on addressing malpractice insurance for licensed staff, worker's compensation insurance, and general property liability insurance..
- Respondent's proposed technology needs, including software and hardware.

RESPONSES

Parties interested in providing information to FSSA should submit **an original and <u>10</u> copies of the written response to:**

Todd Durnil
Indiana Department of Administration
Procurement Division
402 West Washington Street, Room W468
Indianapolis, IN 46204

Responses must be received no later than **3 p.m. Eastern Standard Time on 12/21/2005**. The outside of the package (envelope or box) should be clearly marked:

"RESPONSE TO REQUEST FOR INFORMATION 6-25"

Responses will be considered public information once a Request for Proposal (RFP) is complete. If an RFP is not undertaken, the responses are considered public once the decision is made. Questions submitted in response to the previously released draft of this RFI document, along with corresponding answers, are attached as Appendix A.

Please note that Todd Durnil is the State's single point of contact for this RFI. Also note that the usual and customary procedures for selecting a vendor (issuance of an RFP) may follow this RFI. The process will be open to all providers, irrespective of their participation or non-involvement in this information-gathering process.

Appendix A

REQUEST FOR INFORMATION 6-25
Questions and Answers From Draft RFI 6-25 and Community Meetings

1. How can the State of Indiana replace an unsatisfactory Operations & Management (O&M) contractor and still maintain quality patient care?

   The State's contract with the operator will include specific remedies and penalties for unsatisfactory performance. If the contractor did not address any deficiencies in the prescribed time, the State will have the ability to cancel the contract and pursue other management alternatives.

2. What will be the motivation of the new providers in the area of patient turnover?

   Bed allocation will continue to have a major impact on length of stay. The state through its management and oversight of the O & M contractors will monitor patient turnover and the success of patients who are discharged as quality indicators of the contractors' performance.

3. Will the new operators be held accountable to existing [State Operated Facility] SOF policies especially the prohibition on discharging to homelessness (a HUD requirement)?

   Yes.

4. After localization, will the SOFs continue to admit forensic patients?

   Yes.

5. What will be the grievance procedure if a patient's family member is dissatisfied with the patient's treatment?

   Patients would continue to have all currently available legal rights to review of their treatment. If a family member is the patient's legal representative, he/she would exercise the patient's rights in this regard. The state will maintain management responsibility over the O & M contractors and will be an active participant in measuring the quality of care provided by the contractors.

6. How will FSSA assure access to needed inpatient services for indigent persons?

   The State does not see a change with access to DSH funding.

7. Will the localized SOFs provide counseling to individuals with an IQ under 50?

   Admissions criteria will continue to be the joint decision of the gatekeeper and the O & M state facility in conjunction with FSSA.

8. What will prevent the not-for-profit organization from "cherry picking" so the real sick do not get served?

   The not-for-profit will be required to submit an admission plan as a part of the proposal and will be bound to accept any patients assigned through the state's gatekeeping system.

9. How will we care for those who need longer term treatment than a general hospital can give?

   This will be on a case-by-case basis.

10. Will our patients still have the same quality care as they have now?

    The quality of care should meet or exceed that which is currently provided.

11. Will the new operators be participants in the gatekeeper system?

    There are no plans to amend the gatekeeping statutes.

12. The present law concerning gatekeeper refers to "…a state institution administered by the division…" Will the outsourced hospitals be considered state institutions administered by the division?

    The intent is that the gatekeeping system is to be kept intact.

13. Assuming a [Community Mental Health Center] or a group of CMHC's are operating a hospital, will other CMHC's have access to that hospital?

    Yes.

14. Will the regionalized hospitals be responsible for admissions for [Incompetent to Stand Trial] ICST and the [Mentally Ill/Developmentally Disabled] MI/DD population?

    No significant changes in bed mix are contemplated.

15. The Block Grant requires that states establish goals to reduce readmissions to SOF's at 30 and 180 days. Will the outsourced hospitals have goals that fit this?

    Yes.

16. Why does the patient daily care cost differ from SOF to SOF?

    Each SOF has unique cost associated with the facility and treatment plan. One major component of the difference is the cost of the facilities themselves, or the "overhead". There are also differences in the staff to patient ratios at the hospitals.

17. The focus on enabling communities "to exercise control over their own economic destinies" may overlook the role of these facilities in the life of the state as a whole. These hospitals were created to care for the mentally ill from the entire state. How will you ensure they continue to fulfill that wider role?

    Through the contract and through Board governance of the hospital. The State envisions that the board make up would include mental heath professionals, business and community leaders. FSSA would also hold a seat on the board. The state will also maintain oversight of the gatekeeping process for assignment of patients; the hospitals will not have the ability to deny service to a patient that is assigned to it by the state gatekeeping system.

18. Will the O & M contractor be required to use the Behavioral Hospital Information System (BHIS)?

    The required technology has not been determined at this time.

19. How will the transfer of management impact CMHC bed allocation?

    The localization will not impact the CMHC bed allocation. The CMHC bed allocation plan will be reviewed during the transformation process.

20. How will the transfer of management impact Hoosier Assurance Plan/Monthly Enrollment Reimbursement Report (HAP/MERR) for CMHC?

The localization will not impact the Hoosier Assurance Plan. The Hoosier Assurance Plan will be reviewed during the transformation process.

21. Who will be in charge of the hospital and its decision making? Mental health professionals or a board of business and community leaders?

    The composition of the board will be determined by the respondents. The State will insist on having a seat on the board. It is expected that the qualified professionals will be the leaders in day-to-day operation of the hospital, while the state will maintain oversight through the management of the O & M contract.

22. What role will the state play in mental health other than have a seat on the board?

    The State will continue to fund mental health care, administer the gatekeeping system in addition to managing the O & M contract.

23. Has anyone considered the monumental task of developing and monitoring a contract that will include all of the expectations we have for the satisfactory operation of a hospital?

    Yes, but as the State transitions from a health care provider to a purchaser, significant time and talent can be allocated to meet the challenges of contract management.

24. How will the new operators manage to comply with MBE/WBE requirements; i.e., 10% of a $20 million contact when there may be insufficient minority businesses to supply $2 million in services?

    MBE/WBE subcontracting percentages in contracts are goals, not requirements. The respondents will be expected to show good faith efforts toward achieving these goals.

25. In addition to visiting the Kentucky [localized] hospital why not visit the [non-localized] area of Kentucky to see how happy they are with the [localization]?

    The non-localized area of Kentucky is not impacted by the localization of Eastern State Hospital. This is because Kentucky operates on a regional basis for the hospitals where a hospital is responsible for serving a specific number of counties.

26. Will a local CMHC be permitted to partner with an out-of-state corporation to run the SOF?

    The State will only contract with a locally-based, not-for-profit to operate and manage the SOF.

27. Will the State require the O & M contractor to have the capacity to pay startup costs?

    The State currently funds the hospital and will continue to do so. The timing of the State funding to a qualified not-for-profit corporation will be negotiated to facilitate startup to the fullest extent permitted under Indiana law.

28. Will for-profit organizations be allowed to form partnerships with non-profit organizations to bid on the O & M contract?

    While the State will not preclude a public/private partnership from submitting a proposal, the RFI calls for the hospital to be operated by a

locally-based not-for-profit.

29. Why limit RFP's to non-profits if the aim is to infuse an entrepreneurial spirit into the management of the facility?

    The State will only contract with a not-for-profit corporation to operate and manage the SOF. Not for profit corporations are capable of entrepreneurism.

30. May the employees form their own not-for-profit corporation and submit a bid?

    Yes.

31. Why are you letting out of state people bid?

    The State has engaged in the Request for Information, which is a step in the procurement process. This process allows communities to have input in formulating the final Request for Information. While the State will not preclude a public/private partnership from submitting a proposal, the RFI calls for the hospital to be operated by a locally-based not-for-profit.

32. Will the current staff be involved in choosing the not-for-profit?

    No. Because current staff will be employed by the chosen not-for-profit, they cannot be involved in the selection process. We anticipate that there will be employee involvement in the development of the RFP responses.

33. What will be the selection process for the local not-for-profit board of directors?

    The composition of the board will be determined by the respondents. The State will insist on having a seat on the board.

34. To what extent will consumers, families and advocates be included in choosing who will provide the services?

    The stakeholders are encouraged to have input by contacting and working with the SOF in their local area to be active in the development of the RFP responses.

35. Will the regionalized hospitals be required to maintain [Joint Commission on Accreditation of Healthcare Organizations] JCAHO accreditation?

    The hospitals will be required to be accredited.

36. There are a host of rules and regulations and powers provided to state institutions in Indiana Code. Will these transfer to [localized] hospitals?

    As the owner of the facilities and manager of the O & M contract, the state will maintain its responsibilities to administer the rules and regulations, the contractors will assist in the implementation of rules and regulations.

37. If the SOF is no longer a state facility, what standards and guidelines will the not-for-profit follow?

    All of the hospitals currently maintain Joint Commission on Accreditation of Healthcare Organizations (JACHO) accreditation and Centers for Medicaid/Medicare Services (CMS) through Federal Regulations Title 12, 482 conditions of participation for hospitals. The not-for-profits are required to maintain these accreditations and certifications to improve the quality of care and maintain reimbursement status. They will still be state-

owned facilities and the state will manage the O & M contracts assuring compliance with all accreditations, certifications, rules, regulations and codes.

38 What guarantees are there for employee wages and benefits with the O & M contractor?

Current employees will be offered jobs at, or even above, their current wages and with retirement and healthcare benefits comparable to state government. They will be required to pass a pre-employment drug test and background check.

39. Is the current PERF retirement benefit transferable to O & M employment?

Not currently under the current PERF statute but we intend to ask the legislature for the necessary revisions. Representatives from PERF will explain the current options available to transferring employees. The contractor will be expected to make contributions to an employee retirement plan that is comparable to what the State currently pays.

40. Why can't you "free" these hospitals "from the shackles of a bureaucracy which is cumbersome and benignly neglectful at best" (your words) simply by giving the existing hospital management more autonomy?

As long as the hospitals are under State operation, they are subject to restrictive rules in areas such as personnel and procurement. The most practical way to convey more autonomy is to contract for services.

41. Would it be correct to say that if FSSA continues to fund operations of the facility, the employee salaries would come out of that funding?

Yes.

42. What is the number of Approved/Authorized staffing table FTEs and contract/temporary positions at the SOFs?

Please refer to http://www.in.gov/fssa/sof/hospitals.html for detailed financial information.

43. What are the salaries and benefits of the current staff?

Please refer to http://www.in.gov/fssa/sof/hospitals.html for detailed financial information.

44. Under privatization, the Indiana Department of Correction recently cut its psychology staff by 50% and the remaining [staff] had [salary reduced] by $17,000. What would keep that from happening [with localization]?

The objective of the DOC contract was to reduce a cost, which is not the case with this procurement. Contract terms will guarantee that employees who pass a drug screen and criminal background check will have a job with the contractor for at least 12 months, at their current salary and with comparable benefits, subject to dismissal for cause.

45. Will seniority be considered if and when shift assignments are made by the O & M contractor?

The staffing plan would be a component in the response to the RFP.

46. Can the O & M contractor refuse to hire a current employee based on age?

No. The O & M contractor must comply with Federal and State employment regulations.

47 Will the current medical staff level remain the same following localization?

All State employees currently working at SOF will be offered a job provided they pass the pre-employment drug test and background check. Medical staff currently on contract with the state might elect employment with the new contractor.

48. Will current employees have to bid for their jobs?

No. Current employees will need to apply to work for the new contractor. Contract terms will guarantee that employees who pass a drug screen and criminal background check will have a job with the contractor for at least 12 months, at their current salary, and with comparable benefits, subject to dismissal for cause.

49. Will the merit system continue with the O & M contractors?

The system of appointing and promoting civil service personnel on the basis of merit rather than political affiliation or loyalty would not necessarily apply to a not for profit corporation however we would anticipate the respondents addressing a performance management system within their staffing plan as a component in the response to the RFP.

50. How will accumulated employee leave time be handled after localization?

The staffing plan, including leave policies, would be a component in the response to the RFP.

51. Will Disproportionate Share Hospital (DSH) funds continue at the same level to the O & M contractor?

The State anticipates that the Federal government will provide the current level of funding.

52. Will the Mentally Retarded/Developmentally Disabled (MR/DD) funding remain the same for the O & M contractor?

Funding is provided for the hospital, not a specific patient population.

53. What is the length of stay (LOS) by category for the SOFs?

Please refer to http://www.in.gov/fssa/sof/hospitals.html for detailed clinical information.

54. Who will assume the risk management and liability costs for the localized facility?

The O & M contractor will assume the cost.

55. Who will own the SOF capital assets following localization?

The State will continue to own the capital assets.

56. Could there be a financial commitment beyond the three year mark from the State of Indiana to help ensure the proper start up of this venture?

The State will continue to fund the hospital through the appropriations approved by the State Legislators. The State would like to move to a system whereby the funds are paid on a per-patient rate versus our current

system of paying the hospitals in a lump sum. Until that per-patient rate system is developed, we will continue with funding the SOF in a lump sum payment beyond the initial three years.

57. How will insurance (liability) be transitioned for past care?

    The O & M contract will set forth the specific terms of allocation of liability.

58. If the state hospital is localized, what happens to the patients who are unable to contribute monetarily to their treatment?

    There will be no changes in availability and funding of patient care.

59. What effect will localization have on the typically long waits for court-ordered patients to get a bed in state hospitals?

    The goal of localization is to create seamlessness in the flow in and out of the hospital, which ultimately would reduce waiting lists for involuntarily committed patients.

60. Is there a cost savings for the state with localization?

    Cost reduction is not the ultimate goal for this effort. This initiative may or may not enable hospitals to realize cost savings, but localization will enable communities to exercise control over their own economic destinies.

61. How will legal services be funded following localization?

    The O & M will assume the cost.

62. What will be the process of funding capital improvements or emergency needs?

    The State will continue to fund the hospital through the appropriations approved by the State Legislators. The capital funding is appropriated in the biennial budget process.